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MERGER OF SECONDARY DATA

Final Report
August 1985

RESEARCH REPORT

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MERGER OF SECONDARY DATA

1.0 INTRODUCTION

The Physicians' Practice Costs and Income Survey (PPCIS), conducted by the National Opinion Research Center (NORC) under contract to the Health Care Financing Administration (HCFA), offers a wealth of data on physician practice patterns, costs, income, fees, and participation in public payment programs. The analytic potential of the PPCIS is enhanced by the addition of secondary data reflecting the characteristics of the community in which the physician practices and the primary hospital with which the physician is affiliated. For example, local physician competition may be an important factor in a physician's decision to participate in public programs (e.g., Medicaid, Medicare) or to join alternative health plans (such as health maintenance organizations or preferred provider organizations).

This report provides an overview of the secondary data sources that were linked with analytic data files of the PPCIS (section 2), describes the selection of data elements (section 3), discusses the technical process used to merge the secondary data (section 4), and provides examples of the analytic value of linking secondary data to the physician's self-reported data (section 5).

2.0 OVERVIEW OF DATA SOURCES

As shown in Exhibit 2-1, secondary data were obtained from five sources. The 1984 Physician Master File, maintained by the American Medical Association, was the sample frame for the PPCIS. Sociodemographic data for each physician in the sample were obtained from this source including the physician's age, sex, medical school attended, years since licensure, and board certification. The Area Resource File (ARF), a unique resource for health-related research, provided county-level data on physician supply, hospital beds, census population, per capita income, poverty population, and vital statistics. Assembled by Applied Management Sciences under contract to the Health Resources and Services Administration, the ARF itself is a secondary data base containing information from the American Medical Association, American Hospital Association, and Bureau of the Census, among others. The May 1984 version was linked to the PPCIS.

EXHIBIT 2-1

SOURCES OF SECONDARY DATA LINKED TO THE PHYSICIANS' PRACTICE COSTS AND INCOME SURVEY

Name	Source	Unit	Selected data elements
Physician Master File (1984)	American Medical Association (AMA)	physician-level	• physician's age and sex • years since licensure • medical school attended • board certification status
Area Resource File (May 1984)	Office of Data Analysis and Management, Health Resources and Administration, DHHS	county-level	• physician supply • hospital beds • Census population • per capita income • poverty population • births and deaths
AHA Annual Survey of Hospitals (1982)	American Hospital Association (AHA)	hospital-level	• hospital control • bed size • occupancy rate • average daily census • total admissions and beds • Medicare admissions • teaching status
CHER Hospital Data Tape (1981-82)	Center for Health Economics Research (CHER)	hospital-level	• hospital location • date hospital came onto PPS • cost per Medicare admission
HCFA's Interns and Residents (1984)	Health Care Financing Administration (HCFA)	hospital-level	• interns and residents per 100 hospital beds

The majority of the hospital-level data was obtained from the expanded file of the 1982 Survey of Hospitals, conducted by the American Hospital Association. Basic data on ownership and control, bed size, admissions and days (total and Medicare), occupancy, hospital expenses, and teaching status were obtained from this source. Two additional sources provided hospital-level data. The CHER Hospital Data Tape contains data elements from the 1982 AHA tape, as well as data from the 1982 HCFA Wage Index Survey and from 1981 Medicare Cost Reports. This tape was the source of data on the cost per Medicare admission, the date hospitals came onto Medicare's prospective payment system (PPS), Medicare days and costs, and useful recodes on hospital location (e.g., region and urban/rural location). Selected items from the AHA and CHER data tapes were merged onto a single tape by Health Economics Research, and supplied to NORC.

The final data source was a public use tape provided by HCFA on the number of interns and residents per 100 beds for 1984. This tape was released by HCFA in July 1984 and was obtained by special arrangements for this contract through the HCFA Project Officer.

3.0 SELECTION OF SECONDARY DATA ELEMENTS

The selection of the secondary data elements was guided largely by the objectives of the analytic tasks performed by Health Economics Research, Inc. Two tasks in particular guided the selection process: the analysis of Medicare's Physician Participation Agreement (PPA) program and the analysis of the impact of Medicare's Prospective Payment System (PPS) on physicians with a hospital affiliation. The first task demands a small amount of county-level data on physician competition, elderly and poverty population, and per capita income. The second task requires a wealth of hospital-level data that was obtained from the three sources shown in Exhibit 2-1.

Key issues in the selection of the secondary data will be discussed for each of the secondary data sources.

3.1 AMA Physician Master File

The Master File supplemented data collected directly from the physician, reducing slightly the amount of data actually requested in the interview. The data selection was made in conjunction with the planning of the PPA

analysis, for the purpose of comparing those signing the Medicare PPA to those not signing.

The variables that were selected include the physician's age (converted from the birth year), sex, medical school attended (to determine whether the physician was a foreign medical graduate), the number of years since licensure, and whether the physician was board certified.

3.2 Area Resource File

Data selected from the Area Resource File (ARF) fall into six categories: physician (M.D.) data, osteopath (D.O.) data, hospital data, nursing home data, 1980 Census figures, and mortality data (See Exhibit 3-1). Although the goal of the selection process was to obtain a parsimonious set of data elements, in some cases, we erred on the side of including too much, rather than too little data. This is particularly true of the physician (M.D.) data. The May 1984 version of the ARF contains M.D. data as recent as 1981. However, not all data elements are available for 1981, as shown in Exhibit 3-2. For example, the number of physicians in AMA's five broad specialty categories (total and in patient care) are only available for 1979. Thus, 1979 was chosen as the base year, and where available, data for 1981 were also included. This enables an analyst to construct rates of office-based or patient care physician availibility, for the five broad specialty categories, using the most recent data available.

The census population data presented another dilemma in creating a parsimonious set of data elements. We desired data on the age distribution of the population, especially the elderly population. However, the ARF includes only an age-sex distribution, thus doubling the number of data elements required to construct age-specific population rates. The data for all age-sex categories required 16 variables, at 5 columns apiece.

The natality and mortality data were added in response to a suggestion from the HCFA Project Officer. These data are intended to serve as county-level "need" indicators. Data for multiple years have been included to derive a three-year average rate. (A three-year average is more stable than a rate based on a single year.)

To date the PPA and PPS analyses have relied on aggregate measures of physician competition, hopsital bed availability, proportion of the population that is elderly or low-income, and the per capita income.

EXHIBIT 3-1

DATA ELEMENTS FROM THE AREA RESOURCE FILE

Length	Columns	Var. Name	Description
5	123-127	FIPS	FIPS State/County Code
4	294-297	SMSA	SMSA code
MD Vars			
5	611-615	MDTOT81	Total MDs (1981)
5	621-625	MDTOT79	Total MDs (1979)
5	722-726	MDPC81	MDs, Patient care (1981)
5	732-736	MDPC79	MDs, Patient care (1979)
5	792-796	MDOB79	MDs, PC, Ofc. Based (1979)
5	802-806	MDPRIM79	MDs, PC, OB, Prim Care (1979)
5	812-816	MDNONP79	MDs, PC, OB, Not Prim Care (1979)
5	955-959	GPTOT79	GPs, Total (1979)
5	965-969	GPPC79	GPs, Patient care (1979)
4	975-978	GPOB81	GPs, PC, Ofc. Based (1981)
4	983-986	GPOB79	GPs, PC, Ofc. Based (1979)
5	1092-1096	MEDTOT79	Med Spec, Total (1979)
5	1102-1106	MEDPC79	Med Spec, Patient care (1979)
4	1112-1115	MEDOB81	Med Spec, PC, Ofc. Based (1981)
4	1120-1123	MEDOB79	Med Spec, PC, Ofc. Based (1979)

EXHIBIT 3-1 (continued)

DATA ELEMENTS FROM THE AREA RESOURCE FILE

Length	Columns	Var. Name	Description
5	1625-1629	SRGTOT79	Surg Spec, Total (1979)
5	1635-1639	SRGPC79	Surg Spec, Patient care (1979)
4	1645-1648	SRGOB81	Surg Spec, PC, Ofc. Based (1981)
4	1653-1656	SRGOB79	Surg Spec, PC, Ofc. Based (1979)
5	2202-2206	OTHTOT79	Other Spec, Total (1979)
5	2212-2216	OTHPC79	Other Spec, Patient care (1979)
4	2222-2225	OTHOB81	Other Spec, PC, Ofc. Based (1981)
4	2230-2233	OTHOB79	Other Spec, PC, Ofc. Based (1979)
5	2999-3003	UNKTOT79	Unspec, Total (1979)
5	3009-3013	UNKPC79	Unspec, Patient Care (1979)
4	3019-3022	UNKOB79	Unspec, Patient Care, Ofc. Based (1979)
D.O. Vars			
5	6708-6712	DOTOT81	Total DOs (1981)
5	6729-6733	DOPC81	Total DOs, Patient Care (1981)
5	6759-6763	DOOB81	Total DOs, Patient Care, Ofc. Based (1981)
Hospital Vars (1982 AHA)			
3	7664-7666	HOSPTOT	# Hospitals (total)
3	7694-7696	HOSPSTG	# ST Gen hosp
3	7724-7726	HOSPSTNG	# ST non-gen hosp
3	7754-7756	HOSPLT	# LT hosp

EXHIBIT 3-1 (continued)

DATA ELEMENTS FROM THE AREA RESOURCE FILE

Length	Columns	Var. Name	Description
Hospital Vars (1982 AHA) (continued)			
7	8600-8606	BEDSTOT	Hosp. beds (total)
7	8670-8676	BEDSSTG	ST Gen Hosp. beds
7	8640-8646	BEDSSTNG	ST non-Gen Hosp. beds
7	8810-8816	BEDSLT	LT Hosp beds
Nursing Homes			
6	15546-15551	NHTOT	# Nursing homes (1980)
6	15574-15579	NH_MCARE	# Nursing home w/Medicare beds (1980)
6	15712-15717	NHBEDS	# Nursing home beds (1978)
6	15736-15741	NH_MBEDS	# Nursing home beds-skilled Medicare
Census Data (1980)			
8	20581-20588	POPTOT	Census population
5	21053-21057	MALE04	Males, 0-4
5	21063-21067	FEM04	Females, 0-4
5	21073-21077	MALE514	Males, 5-14
5	21083-21087	FEM514	Females, 5-14
5	21093-21097	MALE1524	Males, 15-24
5	21103-21107	FEM1524	Females, 15-24
5	21113-21117	MALE1534	Males, 25-34
5	21123-21127	FEM2534	Females, 25-34
5	21133-21137	MALE3544	Males, 35-44
5	21143-21147	FEM3544	Females, 35-44

EXHIBIT 3-1 (continued)

DATA ELEMENTS FROM THE AREA RESOURCE FILE

Length	Columns	Var. Name	Description
5	21153-21157	MALE4554	Males, 45-54
5	21163-21167	FEM4554	Females, 45-54
5	21173-21177	MALE4564	Males, 55-64
5	21183-21187	FEMALE4564	Females, 55-64
5	21193-21197	MALE65P	Males, 65+
5	21203-21207	FEMALE65P	Females, 65+
4	22586-22589	BLACKPOP	Percent population black
4	22747-22750	URBANPOP	Percent population urban
5	25896-25900	PCINC	Per capita income
5	26100-26104	MEDINC	Median family income
4	26345-26348	POVPOP	Percentage population below poverty
7	26377-26383	POVELD	# persons 65+ below poverty
9	28000-28008	LANDAREA	Land area (1970)
Vital Statistics Data			
5	24908-24912	TDEAD80	Total deaths, 1980
5	24913-24917	TDEAD79	Total deaths, 1979
6	24918-24923	TDEAD78	Total deaths, 1978
5	25782-25186	MORT80	Mortality, under age 1, 1980
5	25187-25191	MORT79	Mortality, under age 1, 1979
5	25192-25196	MORT78	Mortality, under age 1, 1978
6	22991-22996	TBIRTH80	Total births, 1980
6	22997-23002	TBIRTH79	Total births, 1979
6	23003-23008	TBIRTH78	Total births, 1978

EXHIBIT 3-2

PHYSICIAN DATA CONTAINED ON THE AREA RESOURCE FILE: GRID OF DATA ELEMENTS AND YEAR

Specialty*	Total	Patient Care	Office-Based	Primary Care
M.D. Data				
All Specialties (combined)	81, 79	81, 79	79	79
GPs	79	79	81,79	--
Medical	79	79	81,79	--
Surgical	79	79	81,79	--
Other	79	79	81,79	--
Unspecified	79	79	79	--
D.O. Data	81	81	81	

*Represents the American Medical Association's five broad categories.

3.3 AHA Survey of Hospitals

The 1982 AHA Survey of Hospitals contains an enormous amount of data on each hospital's financial picture and staffing patterns, as well as descriptive information on ownership, control, services, capacity, and affiliations. Again, parsimony was a goal, and the analytic tasks served as a guide. Our selection of data elements fall into five basic categories: management structure, hospital operations, total capacity, Medicare involvement, and affiliations. (See Exhibit 3-3.)

Four variables were chosen to reflect the hospitals' management structure: corporate control, ownership of other hospitals, ownership by a corporation, and management under contract. The PPS analysis uses these variables to test certain hypotheses concerning the influence of a hospital's management on changes in physician behavior under PPS.

Average daily census, occupancy rate, and expenses per admission are outcome measures of hospital operations, while bed size measures total capacity (among other things). Several rates of Medicare involvement can be derived from the data on Medicare admissions/days and total admissions/days. The PPS analysis uses the following: average Medicare length of stay, Medicare days as percent of total days, and Medicare admissions as percent of total admissions. Finally, affiliations such as JCAH accreditation, medical school affiliation, and COTH membership are indicators of teaching status and may be proxies for hospital "quality."

3.4 CHER Hospital Data Tape

The Center for Health Economics Research (CHER) has assembled a hospital-level data tape with some unique items not found on the AHA file. Medicare Cost Report (MCR) data from 1981 on cost per Medicare admission and per Medicare day were selected specifically for the PPS analysis of hospital incentives to physicians. (Hospitals with higher Medicare costs may behave differently from lower cost hospitals.)

The CHER tape also contains data from HCFA's 1982 Wage Index Survey, including the date the hospital came onto PPS. (This, too, is expected to have some relationship to hospital incentives to physicians.) Finally, this tape contains some useful recodes on hospital location, including Census

EXHIBIT 3-3

DATA ELEMENTS FROM THE AHA 1982 EXPANDED FILE

Length	Columns	Variable Name	Description
7	1-7	ID	AHA ID number
6	24-29	FISYR	Beginning date of FY
2	30-31	CNTRL	Control code
1	32	ANCORP	Corporate status
1	34	HCORP	Corporate status
1	36	MNGT	Management contract
2	42-43	SERV	Service code
4	510-513	HOSPBD	Total hospital beds
7	514-520	HOSPIPD	Total hospital inpatient days
5	648-652	ADMTOT	Total admissions
5	764-768	MCAREADMH	Medicare admissions
7	769-775	MCAREIPDH	Medicare inpatient days
9	1135-1143	EXPTOTH	Total expenses
1	2183	BSC	Bed size code
1	2184	LOS	Length of stay code
4	2189-2192	ADC	Average daily census
4	2193-2196	OCC	Occupancy rate
1	2282	MSMSAS	SMSA size
1	2283	MAPP1	JCAH accreditation
1	2285	MAPP3	Residency
1	2287	MAPP5	Medical school affilitation
1	2290	MAPP8	COTH member
1	2292	MAPP10	Medicare certification

region (nine divisions), urban/rural location, and a new variable attempting to refine the dichotomous urban/rural indicator. (See Exhibit 3-4.)*

3.5 HCFA Intern and Residents Tape

Although the CHER tape contains a measure of interns and residents per 100 beds, those data have been superceded with newly-released data from HCFA. A decision was made by project staff, in consultation with the HCFA project officer, to acquire the new data tape. (See Exhibit 3-5.) (It is recognized, however, that the data are unedited and unverified.) The data are being used, in the short-term, for the PPS analysis to examine differences in hospital incentives to physicians, according to intensity of teaching involvement.

4.0 Technical Issues in Merging Secondary Data

The merger of secondary data to the PPCIS analytic file was no small task. This section describes the process used to accomplish the linkages. All merges were handled through the SAS computer package.

The AMA Physician Master file was obtained as part of the sample tape for the PPCIS, and contained a unique identifier for each physician that was also present on the PPCIS analytic file. The data from the AMA Physician Master File were linked to the PPCIS file by the physician identification number.

The second linkage was between the Area Resource File and the analytic file. NORC obtained access to the Area Resource File through the Center for Health Administration Studies, University of Chicago. The identifier used to link the two files was the five-digit state and county FIPS code. The FIPS code came from the AMA Physician Master File for most cases. However, those physicians who had relocated required manual coding, with a FIPS code reflecting their new address. The merge between ARF and PPCIS successfully attached county-level data to every record in the PPCIS.

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*This new variable (named ASHBY in Exhibit 3-4) contains five levels: the "core city" of the 100 most populous cities; the "suburban ring" of these cities; "other urban" areas (i.e., within an MSA that does not contain a top-ranked city); "adjacent rural" areas bordering an MSA; and "non-adjacent rural" areas not bordering an MSA.

EXHIBIT 3-4

DATA ELEMENTS FROM CHER HOSPITAL DATA TAPE

Length	Position	Variable Name	Description
4	12	HOSP	AHA hospital identifier
8	1105	MEDCOST1	Cost/Medicare admission
8	1073	T18CST	Medicare costs
8	648	TMEDAY	Medicare days
8	1892	URBAN	Urban/rural dummy
8	624	REGION	Census divisions (9)
8	1484	F_STATE	State FIPS code
8	1500	PPSDATE	Date hospital came on to PPS
8	1908	ASHBY	Ashby urban-rural

EXHIBIT 3-5

DATA ELEMENTS FROM THE HCFA INTERNS AND RESIDENTS TAPE

Field Name	Field Size	Position	Description
PROVIDER-NUMBER	6	1-6	Medicare provider ID
FILLER	2	7-8	Blank
PROVIDER-NAME	35	9-43	Provider name
IR-BEDS	5	44-48	Full-time equivalent interns and residents divided by beds (decimal point and 4 numbers)
FILLER	2	49-50	Blank
MSA-ST	4	51-54	MSA if urban, state number preceded by two blanks if rural
FILLER	6	55-80	Blank

The third merger, between the AHA/CHER tape and the PPCIS was somewhat more complicated. Respondents to the PPCIS with a hospital affiliation were asked to give the name and address of the hospital with which they were primarily affiliated. The coders looked up the hospital's name and address in an AHA directory to find the AHA hospital code (a six-digit identifier). The name and/or address reported by the physician frequently differed from the directory, thus complicating the task and demanding judgment by the coding supervisor. These codes were then merged onto the PPCIS analytic file.

The merger was then made between the AHA/CHER tape (supplied by Health Economics Research, Inc.) and the PPCIS analytic file. The identifier linking the two tapes was again the six-digit AHA code.

The final merger was between the HCFA Interns and Residents Tape and the PPCIS analytic file. This required an intermediate step of linking the AHA codes with a crosswalk to the Medicare Provider Codes (MPC). Additionally some hand-coding of MPCs was required. Not all cases were coded with an AHA code or MPC. In 189 cases, the physician did not have a primary hospital affiliation. In about 50 other cases the physician refused to provide the hospital's name and address, precluding any coding of hospital identifiers. There were 16 cases for which a hospital name was given, but an MPC and/or AHA code could not be found.

The merges of secondary data produced a new analytic file containing invaluable information for policy-relevant research. The final section of this report provides a flavor of the usefulness of these data.

5.0 Illustrative Uses of Secondary Data Linked to the PPCIS

This section draws on examples from two analytic tasks undertaken by Health Economics Research, Inc., to illustrate the value of linking secondary data to the PPCIS. The first example relates to Medicare's PPA program; the second concerns the impact of Medicare's PPS on hospital incentives to physicians.

County-level data on physician availability, per capita income, elderly population, and poverty population were merged onto the physician-level records to enable comparison of "market factors" faced by physicians signing the Medicare PPA (participants) versus those not signing the PPA

EXHIBIT 5-1

PHYSICIANS' MEDICARE PARTICIPATION STATUS AND SELECTED COMMUNITY CHARACTERISTICS

Community characteristic	Physicians with any Medicare patients	Physicians signing the Medicare PPA	Physicians not signing the Medicare PPA
Physicians per 100,000 population	193.2 MDs	195.4 MDs	192.5 MDs
Average percent below poverty	12.0%	12.0%	12.0%
Average percent of population over age 65	11.2%	11.2%	11.3%
Per capita income of county	$9,959	$10,002	$9,929

Data Sources: 1984-85 Physicians' Practice Costs and Income Survey and Area Resource File.

(non-participants). As can be seen in Exhibit 5-1, participants and non-participants faced similar market conditions, at least as measured at the county level. (Of course, the county is not necessarily the preferred unit of analysis, although data for other units of aggregation are less readily available.)

Physician availability is a measure of market competition. At the county level, there was no difference in the availability of patient care physicians for every 100,000 persons in the county. The rates for participants and non-participants were 195 and 193, respectively.

Demand characteristics at the aggregate level also did not differ for participants and non-participants. The county per capita income averaged $9,900 for non-participants and $10,000 for participants. Elderly (over age 65) averaged 11 percent of the population, while the poverty population was 12 percent of the total population.

The second example is drawn from an analysis of perceived changes in inpatient activity due to PPS and other factors. Exhibit 5-2 displays the characteristics of hospitals, according to physicians' responses on changes in inpatient activity. Hospital-level and county-level data are from three secondary sources, as indicated in Exhibit 5-2.

Hospitals that encouraged physicians to increase admissions may be slightly smaller (360 versus 375 beds) and have a higher cost per Medicare admission ($3,129 versus $2,868) than hospitals not encouraging increased admissions. Otherwise, "across-the-board" effects were noted with regard to Medicare dependency, hospital competition, and occupancy rate. Hospital characteristics do not appear to "explain" differences between physicians reporting and not reporting pressures to discharge sooner or reduce tests/x-rays. For example, where physicians reported pressures to discharge sooner, Medicare accounted for 31 percent of all admissions compared to about 29 percent for other hospitals. Finally, no major trends in hospital competition were noted. The number of hospital beds per 10,000 population in the county averaged between 67 and 71 beds, regardless of types of perceived changes reported by physicians.

EXHIBIT 5-2

SELECTED HOSPITAL CHARACTERISTICS AND PPS IMPACTS[a]

Hospital characteristic	PPS Impacts: Discharge sooner		Reduce tests/ x-rays		Increase number of patients admitted	
	Yes	No	Yes	No	Yes	No
Average cost per Medicare admission	$ 2,933	$ 2,886	$ 2,971	$ 2,886	$ 3,129	$ 2,868
Medicare dependency (percent of admissions)	30.5%	28.6%	30.6%	29.7%	30.2%	30.0%
Average bed size per hospital	370	378	373	371	360	375
Occupancy rate	78%	77%	78%	77%	76%	78%
Hospital beds per 10,000 population	66.9	70.7	68.3	67.3	67.6	68.0

[a]Excludes radiologists, anesthesiologists, and pathologists.

Data Sources: 1984-85 Physicians' Practice Costs and Income Survey, 1982 AHA Survey of Hospitals, CHER Hospital Data Tape, and Area Resource File.

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